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ABSTRACT

A study investigated the role of the interpreter in doctor-patient communication by analyzing four complete medical interviews at a large urban hospital, each involving one of two Russian interpreters on staff. Both interpreters were native Russian speakers recently immigrated to the United States. Patients were middle-aged and elderly immigrants with varying English language skills and experience with American health care. Five physicians were involved. Analysis of the discourse in the interviews resulted in development of a model of interpreted medical discourse, including principles of turn-taking, to provide insight into the nature of the relationships created through participants' discourse strategies. In sum, it is concluded that interpreters can control the conversational organization of the medical interview, distribution of turns among the participants, and doctor-patient exchange of information. Direct communication of doctor and patient through the interpreter is the preferred conversational mode because it approximates most closely the normal monolingual interaction and facilitates information exchange. A second common interaction type, in which direct interactions are between doctor and interpreter and interpreter and patient, may result in the interpreter controlling what is said and who gets to talk, endangering quality of care. Contains 25 references. (MSE)

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UNDERSTANDING THE INTERPRETER'S ROLE

An Analysis of Interpreter-Mediated Doctor/Patient Communication

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INTRODUCTION

Despite the growing acceptance of and demand for interpreters, very little is known about the process of interpreting, especially the role interpreters play in the emerging interlingual discourse. While interpreters have become a common presence in many doctor's offices and hospitals, few people understand fully what it is that interpreters do and how their presence affects communication between the medical providers and their patients. In this paper, I will develop a model of interlingual communication that can help uncover the linguistic strategies interpreters use to shape the emerging discourse. I will also discuss ways in which the specific organization of the interpreted discourse can be used to control the structure and the content of the medical encounter.

The main issue that underlies the analysis in this paper is the problem of the interpreter's role. Opinions are divided between those who believe that the interpreter's task is to interpret what is said by other people and those who see the interpreter as a mediator between two different cultures and world views. The proponents of the first position argue that "the principal, overriding responsibility of the interpreter is [. . .] to bridge the language barrier between two or more individuals speaking different languages, so that they are able to communicate freely with each other, almost as if they were speaking the same language" (Downing 1995:2). The proponents of the second view claim that "interpretation needs to provide a cultural framework for what's being said" and that the interpreter may have to advocate for his/her patients (Roat cit. in Building Bridges 1995:3). The analysis presented in the paper will show that if the interpreter

adopts the role of a mediator between the doctor and the patient, s/he may influence the course of the medical encounter to an extent that jeopardizes the quality of the health care.

1 Literature Review

The field of spoken language interpreting is a relatively new area of study. To my knowledge, very few studies have concentrated on interpreting as an interactional event and the role the interpreter plays in structuring this event. Among the few studies that address these issues are Wadensjö's (1992)[1] research on medical and police interpreting, Berk-Seligson's (1990) work on court interpreting, Knapp-Potthoff and Knapp's study of informal legal interpreting (1986), and Downing's (1992) and Athorp & Downing's (1996) research on health care interpreting.

In her book *Interpreting as Interaction* (1992), Wadensjö reports the results of her study of interpreter-mediated interactions in medical and police settings. In her analysis of encounters between Swedish-speaking representative of public institutions (police officers, nurses, and doctors) and their Russian-speaking clients, Wadensjö adapts an interactive approach to "dialogue interpreting." Wadensjö distinguishes between the interpreter's "normative role" which presupposes a close translation of everything that is being said by each party and the "typical role" which the interpreter can adopt to coordinate the conversation. Wadensjö argues that dialogue interpreters are often expected to and do, in fact, use both of these roles in their work.

In her book, *The Bilingual Courtroom* (1990), Berk-Seligson analyzes court interpreting from a sociolinguistic perspective. She finds that court interpreters use various discourse strategies which may alter the pragmatic intent of the speaker's utterance. Among these discourse strategies

[1] Wadensjö (1992) includes a comprehensive review of studies on interpreting and related fields (11-45).

are manipulation of grammatical case (use of active vs. passive verbs) and lengthening of the source-language testimony (Berk-Seligson 1990:97, 119). By conducting mock trials, Berk-Seligson demonstrates that these and other pragmatic alterations made by court interpreters influence the listeners' evaluations of the speakers whose words are interpreted. Berk-Seligson argues that court interpreters and administrators should be made aware of the power that resides in the interpreter's role and that issues of pragmatics should be addressed in interpreter training programs (Berk-Seligson 1990:196-197).

Knapp-Potthoff and Knapp (1986) contrast non-professional and professional interpreting in their analysis of interpreter-assisted interaction in the courtroom and during informal legal advice sessions. Non-professional interpreters (or "mediators") are found to "mediate" between the two principal parties rather than to give literal translations. Non-professional interpreters provide selective interpretations, engage in negotiating solutions, and may act as advisors. As a result of the interpreter's actions, the exchanges between the legal advisor and the interpreter, on one hand, and the client and the interpreter, on the other hand, drift apart becoming two separate though "interweaving" conversations (Knapp-Potthoff and Knapp 1986:156). The interpreter is thus confronted with the difficult task of managing two discourses, which makes it more likely for him to produce misunderstandings.

Downing (1992) underscores the importance of using professionally trained interpreters in health care settings. An interview between a Russian-speaking patient and an English-speaking doctor conducted with the help of an unskilled interpreter (the patient's son) is examined to demonstrate

that unskilled bilinguals often used as interpreters in hospitals and doctor's offices may impede communication between the doctor and the patient. In the analyzed conversation, the interpreter is found to ignore or mistranslate the utterances he fails to understand or lacks the vocabulary to translate adequately; to provide his own responses to questions; to fail to interpret and to distort the messages in the process of interpretation (Downing 1992:21-22). Thus, the study demonstrates that the interpreter's low linguistic proficiency and his lack of understanding of the interpreter's role make it difficult, if not impossible, for the doctor and the patient to communicate with each other.

Athorp and Downing (1996) analyze monolingual and bilingual medical interviews contrasting "monolingual" (doctor and patients speak the same language), "bilingual helper" (bilingual nurse acts as an interpreter), and "interpreted" (professional interpreter is used) modes of communication. The investigators found that in the "bilingual helper mode," the bilingual nurse often assumes a care-giver role which results in decreasing the number of direct doctor-patient interactions and patient-initiated turns (compared to the "monolingual mode"). In the "interpreted mode," the distribution of turns between the speakers is comparable to that in the "monolingual mode": the interpreter's utterances are, for the most part, translations of the doctor's or the patient's words.

In sum, studies on interpreter-mediated communication have emphasized the crucial role the interpreter plays in structuring the discourse between the parties who lack a common language of communication. Researchers have noted that the interpreter can choose to act as a "translating

machine," attempting to provide a close rendition of each utterance, or s/he may try to act as an independent party in the conversation, regulating the flow of the interaction. In this paper, I will attempt to provide a formal account of the differences between these two interpreting styles and to discuss the consequences of each mode of communication for interlingual medical interaction.

II Setting and Methodology

The data for this study were collected at a large midwestern urban hospital. Because of the large number of immigrants served by this medical facility, the hospital keeps a staff of approximately twenty full- and part-time interpreters working in Hmong, Lao, Spanish, Russian, and other languages. For this study, I observed and recorded medical interviews conducted with the help of two Russian on-staff interpreters. A total of about two hours of medical interviews between Russian-speaking patients and English-speaking health-care providers were audio-recorded during the four days of observation[2]. For the analysis, I transcribed two complete interviews involving each of the interpreters. The lengths of the interviews vary between 25 and 35 minutes[3]. Information about the settings and the participants in the interviews is summarized in Table 1.

#	Location (activity)	Interpreter	Medical Provider(s)	Patient(s)
1	Emergency Room (heart problem)	*Interpreter A*: female, native Russian, M.A., age around 40	Doctor 1: female, around 30 Doctor 2: male, around 30	female, Russian immigrant, former doctor, age around 70
2	Eye Doctor's Office (eye exam)	*Interpreter A* (see above)	eye technician, male, around 45, some Russian	Patient 1: female, Russian immigrant, former engineer, age 50 Patient 2: male, Russian immigrant, former engineer, age 58
3	Immigrant Clinic (follow-up exam)	*Interpreter B*: male, native Russian, college student, pre-med, age around 25	physician, male, around 40, some Russian	male, Russian immigrant, age around 65

[2] Recordings were made using a GE model No. 3-5366A walkman with a built-in microphone. The researcher was present in the room throughout the interviews operating the recorder and taking notes when necessary.

[3] Complete transcripts of interviews are available by request.

4	Immigrant Clinic (follow-up exam)	*Interpreter B* (see above)	Doctor 1: same as in 3 Doctor 2: heart specialist, male, around 45	female, Russian immigrant, around 70

TABLE 1: Summary of Transcribed Interviews

The interpreters participating in the study are both native Russian speakers who immigrated from the territory of the former Soviet Union to the U.S. quite recently (four-six years ago). Both have worked as medical interpreters for a number of years. They have also participated in the professional training program for community interpreters conducted at the University of Minnesota, though *interpreter A* had had a great deal more training than *interpreter B* who had not completed the full course of studies. At the time of the study, *interpreter A* had worked at the hospital for half a year and *interpreter B* for two and a half years.

The patients participating in the study are middle-aged and elderly immigrants from the former Soviet Union with very limited or no knowledge of English and various degrees of experience with the American health-care system. The medical providers are English-speaking doctors and other medical personnel who may or may not have had experience working with non-English speaking clients and interpreters. Some of them had worked with so many Russian clients that they acquired a number of basic Russian words and phrases (see Table 1). It is necessary to note that due to scheduling difficulties, I was unable to administer a formal questionnaire about the participants' background and experience. The data presented in Table 1 surfaced during the recorded interviews.

III A Model of Interpreted Medical Discourse

A. Introduction

In order to develop a model of interpreted doctor/patient discourse, three facts have to be taken into account. First, interpreted medical discourse is an interactional event that involves three or more parties (doctor(s), patient(s) and interpreter[4]); thus, methods of conversational analysis can be applied to study its organization. Second, interpreter-mediated discourse is a specific kind of interaction in which the physician and the patient speak different languages and cannot directly communicate with each other, while the interpreter can interact linguistically with both parties. Third, it differs from other conversations in that it takes place within an institution and is, thus, constrained in its goal (exchange of medical information between doctor and patient) and organization (defined by status relations among the participants).

As an interactive event, interpreted discourse has to have a mechanism to distribute the floor among speakers. In an ordinary conversation, such a mechanism is locally managed, i.e. turns are allocated on a turn-by-turn basis. According to Sacks, Schegloff, and Jefferson (1974), speakers are selected or self-select themselves at the end-of-turn (a transition relevance place) recognized by the listeners in the speech of the current speaker. Since the listeners' ability to recognize transition relevance places is contingent on their immediate understanding of the current speaker's utterance, this turn-taking system cannot be unconditionally applied to interpreted discourse. Moreover, the system of local turn allocation is fully applicable to non-institutional discourses

[4] In interpreted doctor/patient discourse, interpreters are generally present in the room and work in consecutive mode.

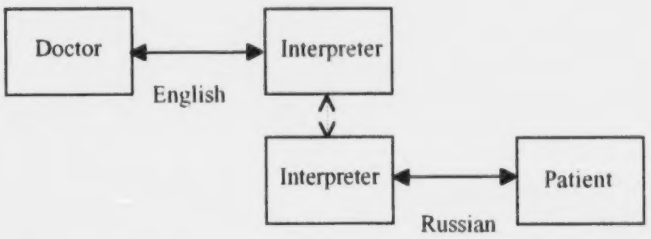
only, since in institutional settings, "turns are (at least in part) pre-allocated rather than determined on a turn-by-turn basis" (Levinson 1987:301).

In this paper, I will develop a model of interpreted medical discourse that will include principles of turn distribution among the speakers. Furthermore, since principles of turn allocation are closely associated with the institutional roles assigned to and assumed by the participants, the model will provide insight into the nature of the relationships created through the participants' discourse strategies.

B. Organization of Interpreter-Mediated Doctor/Patient Interaction

Analysis of the collected data shows that medical interviews conducted through an interpreter are realized in one or the other of two conversational modes. First, an interview may take the shape of a single conversation between the two principal parties, the doctor and the patient, with the interpreter being a conveyer of their messages (Type 1). Second, an interview may be realized as a combination of two parallel (but not identical) interactions between the doctor and the interpreter (in one language), on one hand, and the patient and the interpreter (in another language), on the other hand, with the interpreter shifting back and forth between the two conversations (Type 2). These two modes of interaction are represented graphically in Figure 1. During the course of a single interview, the conversation shifts between these two styles.

a) Type 1 interaction



b) Type 2 interaction

Figure 1. Two modes of interlingual communication

In type 1 interaction, all interpreter's turns are pre-allocated and scripted. In order for the conversation to proceed, utterances have to be interpreted on a turn-by-turn basis. The interpreter's turns are, thus, pre-allocated according to the following rule:

(1) interpreter takes floor (to translate the message from the source language into the target language) at the end of turn of the current speaker (doctor or patient).

The end-of-turn occurs at a transition relevance place (TRP) marked by either intonation, pause, or other signal (such as gaze or gesture) (Levinson 1987:297). The doctor and the patient allocate the floor according to the following rule (adapted from Sacks et al. 1974):

(1') the next speaker (patient/doctor) can be either selected (through interpreter) by the current speaker (doctor/patient) or can select him- or herself at the TRP recognized in the speech of interpreter. The current speaker can continue his/her turn if the next speaker does not select him- or herself at the end of interpreter's speech.

Rules (1) and (1') predict that in this interactional mode the interpreter can never be addressed directly by either the doctor or the patient, and, thus, can never be selected or select him- or herself as the next independent speaker (hence the dashed line in Figure 1a). Moreover, the content of the interpreter's turns is fully determined by the current speaker. Essentially, the interpreter echoes, in a different language, what the current speaker has just said. While inaccuracies of interpretation can and do occur, each turn of the interpreter is recognizable as an attempt to translate the previous utterance.

The following is an example of a type 1 exchange:

Extract 1 (dialogue 1)[5]

240		D1:	And how about you (?) How many years are you //now in this country (?)]
241	→	I:	*[How many] years are you in this country (?)*
242		P:	*Ten days*
243	→	I:	Ten days
244		D2:	//Oh (!)]
245		D1:	[Ten] days (!) Are you visiting or are //you here for good (?)]

[5] See Table 1 for information about the dialogue. Italics mark the Russian speech. D1 and D2 - doctors; P - patient; I - interpreter. For transcribing conventions, see Appendix 1.

246 → I: *[You came] for good or=*
247 P: *=For good*
248 → I: For good
249 D1: Good (.) O.K. (.) Now are you retired from: from:=
250 → I: *Are you retired (?)*
251 D2: =your //country's]=
252 P: *[Yes]*
253 D1: =cardiology department (?)
254 → I: Oh yes
255 P: *//I would love to work*]
256 → I: *//You worked in the cardiology department] and then retired //right](?)*
257 P: *[Oh] God I worked to the very last day //( )]*
258 → I: [I worked] to the very last day I left for this country
259 D2: Um-um

In this extract, the doctor addresses the patient directly, which is evident in the use of the second rather than the third person pronoun ("you" in lines 240, 245, and 251). The interpreter shadows the principal speakers (lines 241, 243, 246, 248, 250, 254, 256, and 258) preserving the first person pronoun in her interpretation ("I" in line 258). The interpreter is never addressed by the principal parties and takes the floor only to interpret.

In type 2 conversation, the direct interactions are between the doctor and the interpreter, on the one hand, and the patient and the interpreter, on the other hand, but not between the doctor and the patient. Transitions between these two conversations are conducted by the interpreter who may choose to switch from one conversation to another in order to, for example, report the content of the conversation to the other party or to get additional information--often in response to a directive from the doctor to obtain and report information from the patient. Thus, the participants address the interpreter directly, which means that the interpreter can be selected as a next principal speaker as well as select him- or herself. In each of the parallel conversations,

doctor/interpreter and interpreter/patient, the turn-taking mechanism is comparable to the mechanism described by Sacks et al. (1974):

(2) next speaker can be either selected by the current speaker or self-selects him- or herself at the TRP. The current speaker can continue his/her turn if the next speaker does not select him- or herself.

The content of the interpreter's turns is not fully determined by other speakers. Instead, the interpreter may summarize the doctor's or patient's words; ask his/her own questions; answer questions posed by the parties, express his/her opinion about the doctor's and patient's words, request and make clarifications, etc. Rule (2), thus, implies that in this type of interaction, the interpreter's turns are neither pre-allocated nor scripted.

The following includes an example of a type 2 interaction:

Extract 2 (dialogue 4)

25	D:	How how often do you have the chest pain over here (?)
26	I:	*How often do you have pain (#) here (,) on the left side (?)*
27	P:	*Often (2.5) well especially when the weather changes I just lie flat*
28 →	I:	*Faina (,) often (,) how often does it happen (?) once a week (,) three times a week (,) every day (?)*
29	P:	*Three times and five times it depends*
30 →	I:	Pretty much every day (#) ((softly:)) the way I understand
31	D:	How long does the pain last (?) this one (.) ((pointing))
32	I:	*How long does it last when it starts (?)*
33	P:	*Well when it starts I take medications right away*
34 →	I:	*What do you take (?)*
35	P:	*The stuff they gave me to take twice I forgot what it's called*
36 →	I:	*Did you bring it with you (?)*
37	P:	*Um-um (#) he has it written down*
38 →	I:	Ah:: (2) *you take the pills and the pain goes away right immediately or how soon does it go away (?)*
39	P:	*In about ten minutes*
40 →	I:	Ten minutes after she takes the medications ah the medications that you gave her (,) that she's supposed to have twice a day=
41	D:	=Yeah

In this extract, utterances 25-27 are prototypical for a type 1 interaction. In line 25, the doctor addresses the patient with a question. The question is translated by the interpreter (line 26) and answered by the patient (line 27). Type 1 interaction is, however, aborted by line 28 when the interpreter initiates his own question. As a result, the interpreter converses with the patient (lines 26-29 and 32-39) while the conversation between the doctor and the interpreter is on hold. The interpreter self-selects himself to ask the patient questions (lines 28, 34, 36, and 38) which are not asked by the doctor. Reporting the patient's answers to the doctor, he uses the third rather than the first person pronoun ("she" in line 40) and adds his own comments (line 30). Note also that the interpreter's definition of the interaction is not shared by the doctor who addresses his questions to the patient rather than to the interpreter (see a second person pronoun "you" in line 25). The analysis of the data reported in the following sections shows that, as in this example, the participants in an interpreted discourse may differ as to how they define the ongoing discourse (as type 1 or type 2) and a single discourse may move frequently from one type to the other.

IV Quantitative Analysis

A. Number of Type 1 and Type 2 Interactions

Analysis of the recorded data shows that participants in the interviews differ in the way they perceive and organize the discourse. Since each turn allows the speaker to choose his/her addressee, a turn-by-turn analysis can determine the speaker's perception of the emerging discourse. Thus, if the doctor chooses to address the patient directly, he adheres to type 1 interaction. If, on the other hand, the speaker's addressee is the interpreter, he perceives the interaction as a type 2. Arguably, each participant has his/her own preferred model of interaction which s/he may choose to follow throughout the conversation or to substitute for another one when desired. If such preferences do in fact exist, they will be revealed during the course of the interview. In this section, I will analyze the distribution of type 1 and type 2 interactions with the purpose of uncovering the participants' tendencies in the organization of the discourse.

I conducted a turn-by-turn analysis of the dialogues in order to determine who the speaker's addressee is. The major difficulty was the absence of visual information, since non-verbal clues, such as the direction of gaze, body orientation, facial expression, etc., are rich sources of information about a speaker's intended addressee. In the absence of this information, I often had to make arbitrary decisions about whom the speaker addresses in each turn. I chose to follow a conservative rule according to which an interaction is considered to be type 1 unless there is evidence to the contrary. Such evidence can be a reference to the doctor or the patient in the third person (such as "the doctor says," "she's complaining," "ask him," etc.); situations in which

the interpreter questions one of the parties or provides his/her answers; summary interpretations; interpreter's opinions, comments and elaborations. Back-channeling and acknowledgment responses (such as *uhuh*, *OK*, etc.) were excluded from the analysis. Table 2 summarizes the results of the analysis.

	Dialogue 1		**Dialogue 2**		**Dialogue 3**		**Dialogue 4**	
	(with *interpreter A*)				(with *interpreter B*)			
	type 1	type 2	type 1	type 2	type 1	type 2	type 1	type 2
I (English)	78%	13%	52%	40%	21%	72%	44%	54%
I (Russian)	66%	24%	71%	25%	40%	59%	43%	56%
I (total)	73%	18%	60%	34%	34%	63%	44%	55%
D1	53%	28%	23%	54%	78%	13%	72%	11%
D2	25%	38%	-	-	-	-	36%	56%
P1	84%	13%	45%	35%	39%	55%	50%	39%
P2	-	-	58%	12%	-	-	-	-

TABLE 2: Type 1 and Type 2 Interactions as Percentage of Total Number of Utterances

The analysis shows that *interpreter A* (dialogues 1 and 2) is involved mostly in type 1 interactions, while *interpreter B* (dialogues 3 and 4) uses mostly type 2 interactions. Doctor's preferences vary from case to case. Patients' preferences seem to reflect the interpreter's preferences: Patients working with *interpreter A* use type 1 interaction most of the time, while patients working with *interpreter B* mostly employ type 2 mode.

B. Distribution of Type 2 Turns

Not only is the amount of each type of interaction important, but also the purpose it serves for the participants. Since type 1 is considered default, type 2 turns are the ones analyzed. In the recorded data, type 2 turns (in which the interpreter is an independent participant) are employed to perform the following actions:

(1) **clarification request:** a request to clarify a word or phrase in the immediately prior turn. The request can be made by any participant.

Extract 3 (dialogue 1):

118 I: *Have you ever had an angiogram done (?)*
119 → P: *Angiogram (?)*

If the doctor or the patient requests a clarification, it may or may not result in engaging the interpreter in a type 2 interaction since the interpreter may either proceed to make the required clarification him- or herself (see (2) below) or re-address it to the other party. All interpreter-initiated requests are, by definition, type 2 turns.

(2) **providing clarification**: responding to the request for clarification by repeating a word/phrase in question, paraphrasing the statement, or confirming the suggested reading.

Extract 4 (dialogue 1):

118 I: Have you ever had an angiogram done (?)
119 P: *Angiogram (?)*
120 → I: *Um-um*

(3) **providing cultural background**: the interpreter fills in the information s/he perceives as crucial for understanding the message of the prior speaker. Interpreter-initiated explanations

of medical terms employed by medical practitioners are not included in this category (see (9) below).

Extract 5 (dialogue 1):

229 → I: No actually she mentioned a medication and the Russian name for it is Klofelin (,) I don't know if it makes any sense to you (?)

(4) **meta-talk**: conversation about the conversation, such as expressing doubts as to whether the interpreter can translate the speaker's words or whether the hearer understands the message.

Extract 6 (dialogue 1)

58 → P: =*I had a heart attack I don't know how //to translate this]*

(5) **initiating a question**: the doctor or the patient pose a question addressed to the interpreter rather than to the other party or the interpreter asks his or her own question.

Extract 7 (dialogue 1)

65 → D2: OK (.) Does she know what kind of a (#) infarct it was(?) what //kind of a heart attack (?)]

(6) **answering a question**: the doctor or the patient answers a question initiated by the interpreter or the interpreter proposes his/her own answer to a question posed by the doctor or patient.

Extract 8 (dialogue 3)

19 D: Ahm::: (#) so it's not clear to me does he- does he take his blood pressure medicine everyday you'll (ask him)

20 → I: Yeah

(7) **third person interpretation**: interpreter's translation of the prior speaker's utterance includes a reference to that speaker in the third person.

Extract 9 (dialogue 1)

498 D1: I don't hear an S3

499 → I: *She doesn't feel an S3*

(8) **summary interpretation**: providing a summary rather than a complete translation of the prior turn(s).

Extract 10 (dialogue 4)

25	D1:	How how often do you have the chest pain over here (?)
26	I:	*How often do you have pain here (#) che- on the left side (?)*
27	P:	*Often (2.5) well especially with a change in the weather (#) and then I just lie like flat*
28	I:	*Faina often how often does it happen (?) once a week (,) three times a week (,) every day (?)*
29	P:	*Three times and five times it depends*
30 →	I:	Pretty much every day (#) ((softly:)) the way I understand

(9) **comments, elaborations, instructions, requests**: doctor's or patient's comments, instructions, and requests that refer to the other party in the third person; interpreter-initiated comments and elaborations on the message being interpreted, etc.

Extract 11 (dialogue 3)

92	P:	*(5.3) I also wonder I go to school and maybe I don't know ah kind of well (#) ah: maybe you can't understand something or what you don't know (,) all those worries (,) I am afraid when the blood pressure goes up a lot here when I come back from school=*
93 →	I:	*=You have a headache //you]=*
94	P:	*Yes yes*
95 →	I:	*=You don't know if it goes up you don't measure the blood pressure=*
96	P:	*=Yes I have a headache headache (,) but I feel (,) //sometimes]*

(10) **initiating a side conversation**: doctor, patient, or interpreter initiate a conversation with a party not participating in the interview (such as a nurse or an observer) or with another party in the conversation on a subject unrelated to the interview.

Extract 12 (dialogue 1)

234 →	P:	*Nina excuse me how many years have you been here in America (?) I want to*
235	I:	*Three and a half years*
236	P:	*Yeah //and you speak like that]*

(11) **participating in a side conversation**: engaging in a side conversation as defined above.

Extract 13 (dialogue 1)

234 P: *Nina excuse me how many years have you been here in America (?) I want to*
235 → I: *Three and a half years*
236 → P: *Yeah / and you speak like that]*

Tables 3-6 provide summary information on distribution of type 2 turns for the four analyzed dialogues. Numbers indicate the percentage of the total number of turns (type 1 and type 2) used to fulfill a particular type 2 function (as described above).

Table 3 demonstrates that in dialogue 1:

- *Interpreter A*'s and the patient's type 2 turns are evenly distributed among various functions. The percentage of type 2 turns fulfilling a particular function is low;
- Doctor 1 and doctor 2 use a large percentage of turns (11% and 22%) to pose type 2 questions (questions addressed to the interpreter rather than to the patient);
- Doctor 1 uses a large proportion of her turns (11%) to make type 2 comments (comments addressed to the interpreter rather than to the patient).
- Doctor 2 uses a large proportion of his turns (9%) to request clarifications from the interpreter.

Table 4 demonstrates that in dialogue 2:

- *Interpreter A* uses a large portion of her turns to participate in side conversations with the doctor (14%) and with the patients (9%);
- The doctor uses 16% of his turns to pose type 2 questions addressed to the interpreter;

- 11% of the doctor's turns are used to make type 2 comments;
- The doctor uses 14% of the turns to participate in a side conversation with the interpreter;
- Patient 1 uses 15% of her turns to participate in a side conversation with the interpreter.

Table 5 demonstrates that in dialogue 3:

- 30% of *interpreter B*'s turns in Russian are interpreter-initiated questions to the patient;
- 19% of *interpreter B*'s turns in Russian are interpreter-initiated comments, instructions, etc. to the patient;
- 10% of *interpreter B*'s turns in English are interpreter-initiated questions to the doctor;
- 10% of *interpreter B*'s turns in English are interpreter-initiated comments to the doctor;
- Almost a third of interpreter's turns in English (31%) are summary interpretations of the patient's words;
- The doctor rarely uses type 2 turns;
- 45% of the patient's turns are answers to the interpreter-initiated questions.

Table 6 demonstrates that in dialogue 4:

- 29% of interpreter's turns in Russian are interpreter-initiated questions to the patient;
- Out of all interpreter's turns in English, 16% are third person and 21% are summary interpretations of the patient's words;
- Doctor 1 rarely uses type 2 turns;
- 32% of doctor 2 turns are type 2 questions (directed to the interpreter rather than the patient);
- 20% of doctor 2 turns are type 2 comments, instructions, etc.;

- 21% of the patient's turns are answers to the interpreter-initiated questions.

In sum, the analysis of type 2 turns shows that while the participants sometimes use type 2 turns for such communication-promoting functions as requesting and providing clarifications, the majority of type 2 turns are used for functions that restrict direct communication between the doctor and the patient and emphasize the interpreter's involvement and his/her independent role in the interaction. The redefinition of direct doctor-patient communication (type 1) as doctor-interpreter-patient interaction (type 2) may be initiated by the doctors (as in dialogues 1, 2, and, partially, 4) or by the interpreter himself (as in dialogues 3 and 4). The patient's role in determining the type of interaction seems insignificant, since s/he usually follows the interpreter's lead. In fact, the majority of patients' type 2 turns are answers to interpreter-initiated questions (as in dialogues 3 and 4).

Action	Interpreter A (% total)			Doctor 1 (% total)	Doctor 2 (% total)	Patient (% total)
	Russian	English	Total			
Clarification request	3		1		9	2
Providing clarification	3	3	3			2
Providing cultural background	3	1	1			
Meta-talk	2	1	2			2
Initiating a question	3	1	1	**11**	**22**	1
Answering a question	2	1	1	3	1	3
Third person interpretation	3	1	2			
Summary interpretation		1	1			
Comments, elaborations, instructions, requests	3	2	4	**11**	3	4
Initiating a side conversation	1		1	4	1	1
Participating in a side conversation	1			1	3	1
Total (type 2)	**24**	**11**	**17**	**30**	**39**	**13**

TABLE 3: Distribution of Type 2 Turns in Dialogue 1 (in percentage of total number of turns)

Action	Interpreter A (% total)			Doctor (% total)	Patient 1 (% total)	Patient 2 (% total)
	Russian	English	Total			
Clarification request		1	1	3		
Providing clarification		4	2	1		
Providing cultural background						
Meta-talk						
Initiating a question		4	2	**16**	5	
Answering a question		4	2	4		
Third person interpretation		2	1			
Summary interpretation	7	2	4			
Comments, elaborations, instructions, requests	7	3	5	**11**	8	8
Initiating a side conversation	1	5	4	5	8	
Participating in a side conversation	9	**14**	**12**	**14**	**15**	5
Total (type 2)	**24**	**39**	**33**	**54**	**36**	**13**

TABLE 4: Distribution of Type 2 Turns in Dialogue 2 (in percentage of total number of turns)

Action	Interpreter B (% total)			Doctor (% total)	Patient (% total)
	Russian	English	Total		
Clarification request				2	
Providing clarification		3	1		
Providing cultural background					
Meta-talk		3	1	2	
Initiating a question	**30**	**10**	**24**	2	6
Answering a question	2	7	3	7	**45**
Third person interpretation	6	**10**	8		
Summary interpretation	2	**31**	**11**		
Comments, elaborations, instructions, requests	**19**	7	**15**		4
Initiating a side conversation					
Participating in a side conversation					
Total (type 2)	**59**	**71**	**63**	**13**	**55**

TABLE 5: Distribution of Type 2 Turns in Dialogue 3 (in percentage of total number of turns)

Action	Interpreter B (% total)			Doctor 1 (% total)	Doctor 2 (% total)	Patient (% total)
	Russian	English	Total			
Clarification request	6	3	3		4	2
Providing clarification		1	1			5
Providing cultural background	1		1			
Meta-talk						
Initiating a question	**29**	4	**18**		**32**	
Answering a question		6	3	4		**21**
Third person interpretation	6	**16**	**10**			
Summary interpretation	1	**21**	**10**			
Comments, elaborations, instructions, requests	6	6	6	6	**20**	6
Initiating a side conversation	1		1			1
Participating in a side conversation	7		4			5
Total (type 2)	**57**	**54**	**57**	**10**	**56**	**40**

TABLE 6: Distribution of Type 2 Turns in Dialogue 4 (in percentage of total number of turns)

C. Effects of the Interpreter's Preferred Mode of Interaction on the Course of the Interview

In order to see how the type of interaction affects the course of the medical interview, the number of questions, answers, and comments initiated by the parties in each interview, as well as the number of utterances translated by the interpreter were counted. Figures 2-9 demonstrate some of the results of the quantitative analysis.

Figures 2 and 3 refer to dialogue 1, in which *interpreter A* uses type 1 interaction 73% of the time (see Table 2). Figures 2 and 3 show that the majority of doctors' and patient's utterances are translated for the other party (71% of the doctors' utterances and 83% of the patient's utterances). The number of interpreter-initiated questions, answers, and comments is low for both doctor/interpreter and patient/interpreter interactions.

Figure 4 and 5 refer to dialogue 2 in which *interpreter A* uses type 1 interaction 60% of the time: 52% in English and 71% in Russian (see Table 2). Figures 4 and 5 show that the majority of the doctor's and the patients' utterances are interpreted for the other party (79% of the doctor's utterances and 64% of the patients' utterances). The number of interpreter-initiated questions, answers, and comments is low, in particular in interpreter/patient interactions. The higher number of interpreter-initiated utterances in interpreter/doctor interaction coincides with the higher number of the interpreter's type 2 turns in English (40% in English versus 25% in Russian).

Figures 6 and 7 refer to dialogue 3, in which *interpreter B* uses type 2 interaction 63% of the time (see Table 2). Figure 6 shows that the majority of doctor's utterances are interpreted (74%).

Figure 7, on the other hand, demonstrates that only 22% of the patient's utterances are interpreted for the doctor. In particular, only 9% of the patient's answers are interpreted. At the same time, Figure 7 shows that, in his conversation with the patient, the interpreter initiates four times more questions than does the patient and makes twice as many comments as does the patient.

Figures 8 and 9 refer to dialogue 4 in which *interpreter B* uses type 2 interaction 55% of the time. Figure 8 shows that the majority of the doctors' utterances are interpreted for the patient. Figure 9, on the other hand, demonstrates that only 50% of the patient's utterances are interpreted for the doctors. Figure 9 also shows that interpreter initiates approximately four times as many questions in his conversation with the patient than does the patient.

In sum, figures 2-9 demonstrate that *interpreter B,* working in type 2 interactional mode most of the time, exercises more control over the flow of interaction between the doctor and the patient than *interpreter A* who uses type 1 interaction most of the time. A wider usage of type 2 interaction usually coincides not only with a higher number of interpreter-initiated utterances, but also with a lower percentage of doctors' and patients' utterances being translated by the interpreter for the other party .

In the following sections, I will look in more detail at how the interpreter can influence the course of the medical interview. In particular, I will analyze (1) how the interpreter can control the way in which turns are distributed among the speakers (section VI-B); (2) how the interpreter can influence the exchange of information among the participants (section VI-C); and (3) how s/he

can control the organization of the emerging discourse (section VI-D). I will analyze these three strategies in terms of the two-mode model of interpreted discourse introduced above (section III-B).

Fig 2: Doctor/Interpreter Interaction

Dialogue 1

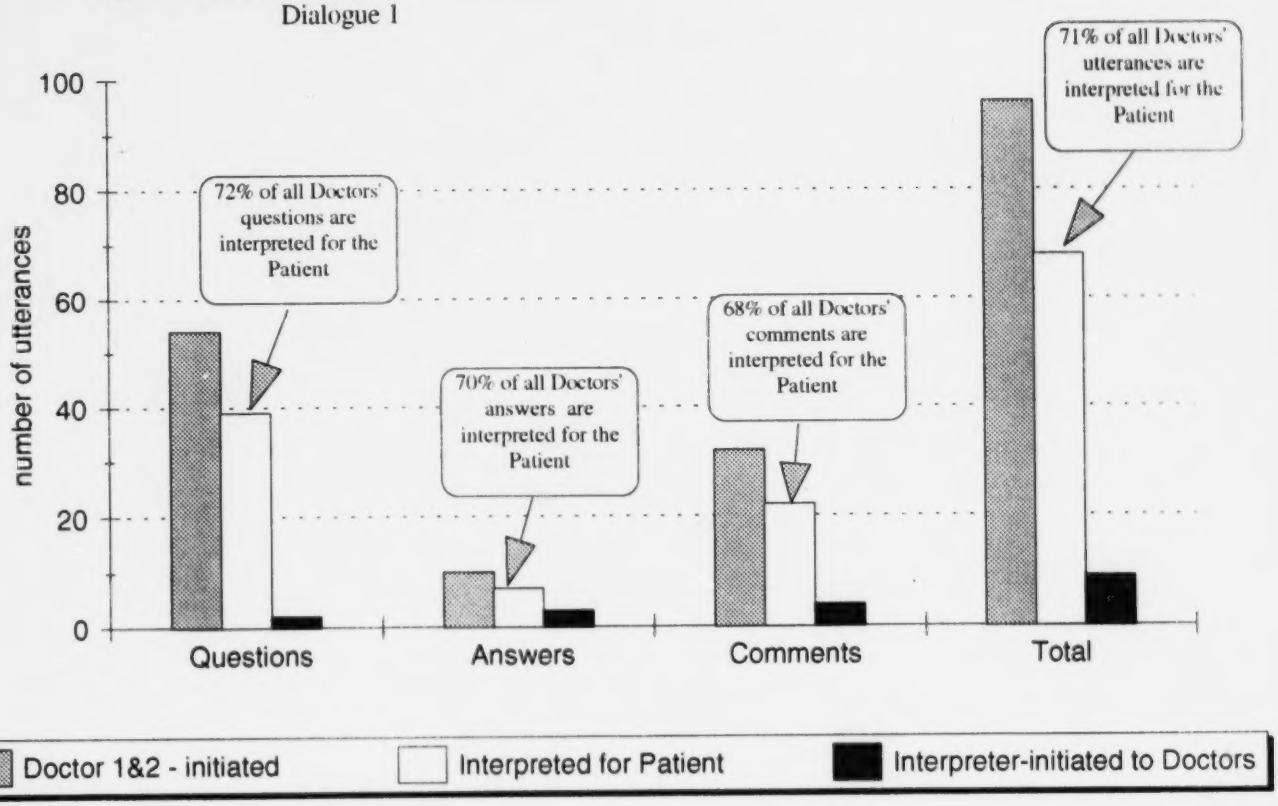


Fig 3: Patient/Interpreter Interaction

Dialogue 1

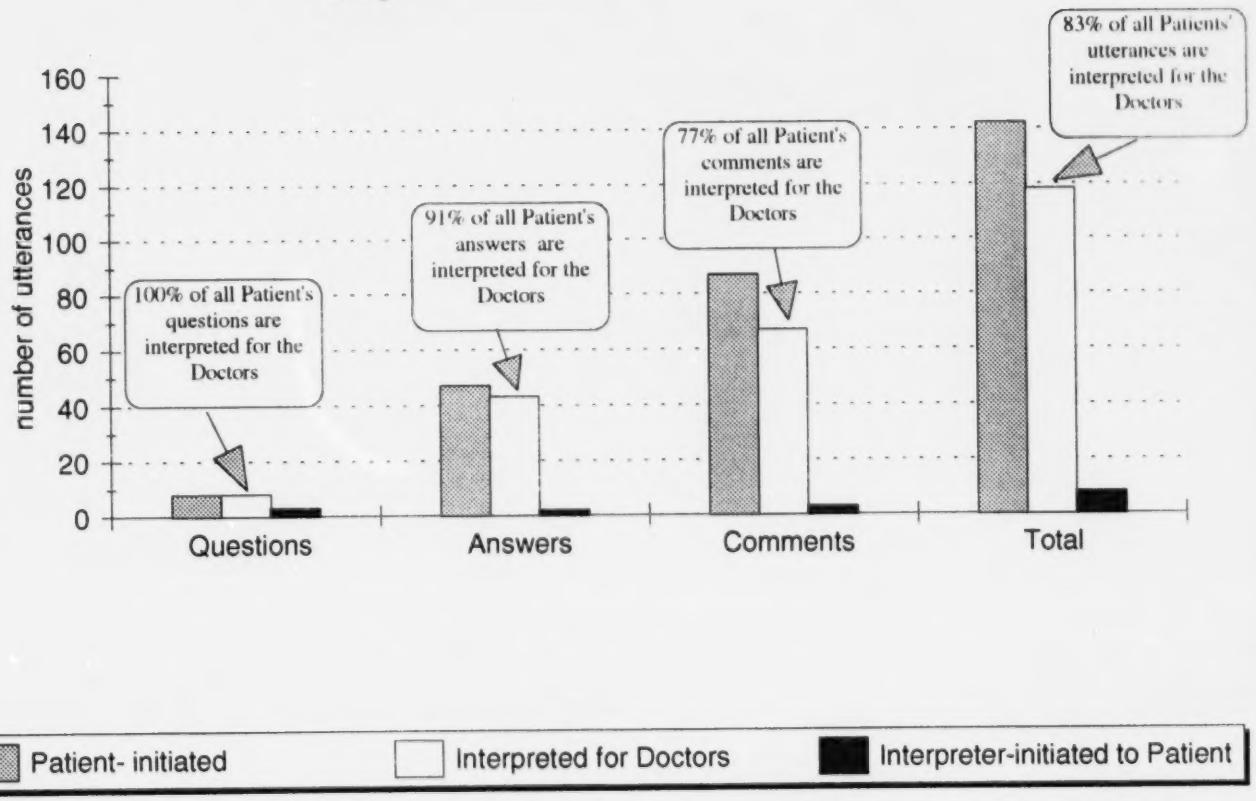


Fig 4: Doctor/Interpreter Interaction

Dialogue 2

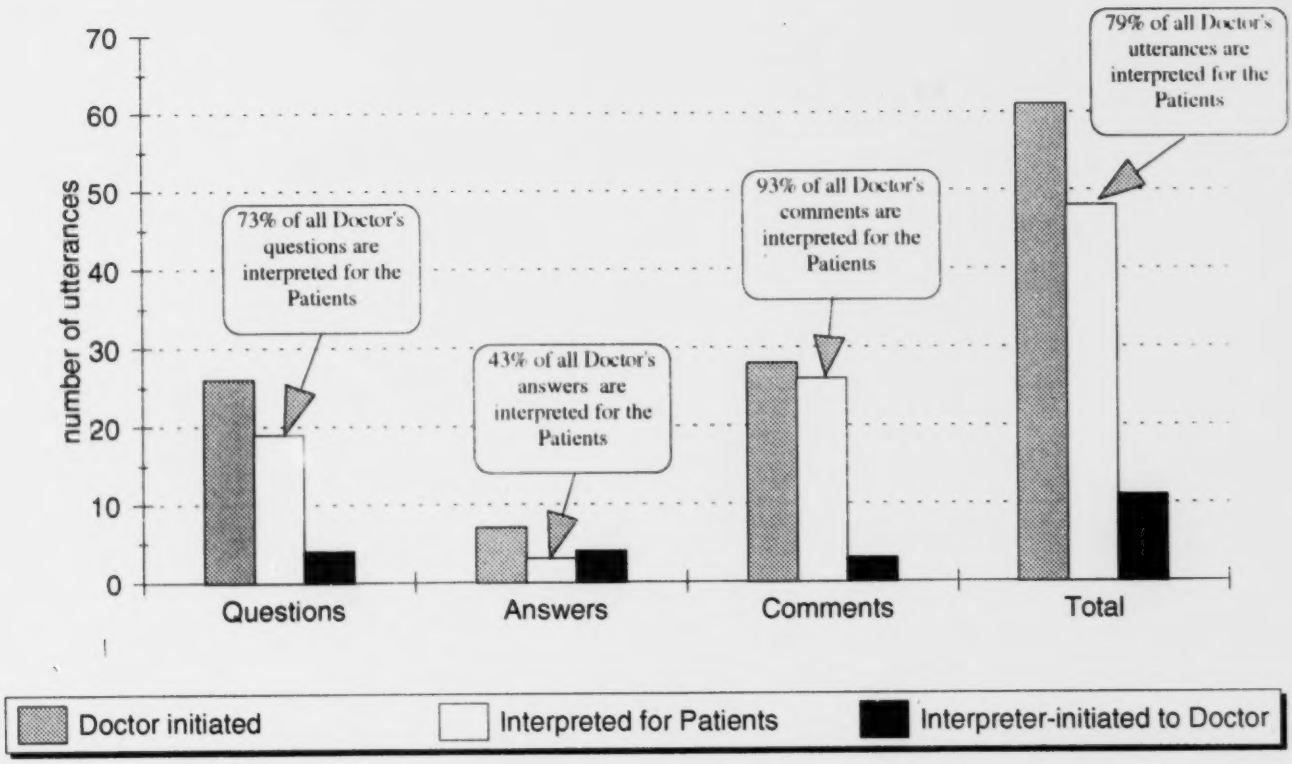


Fig 5:Patients/Interpreter Interaction

Dialogue 2

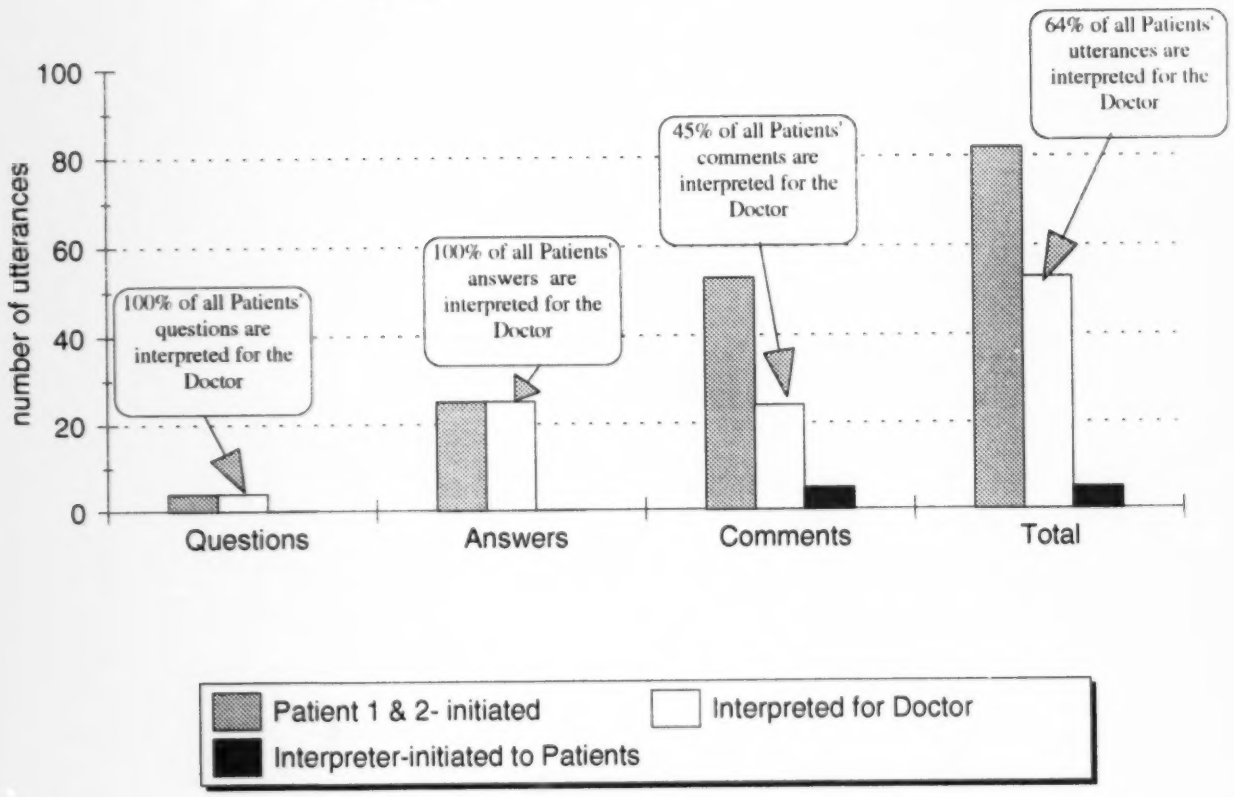


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Fig 6: Doctor/Interpreter Interaction

Dialogue 3

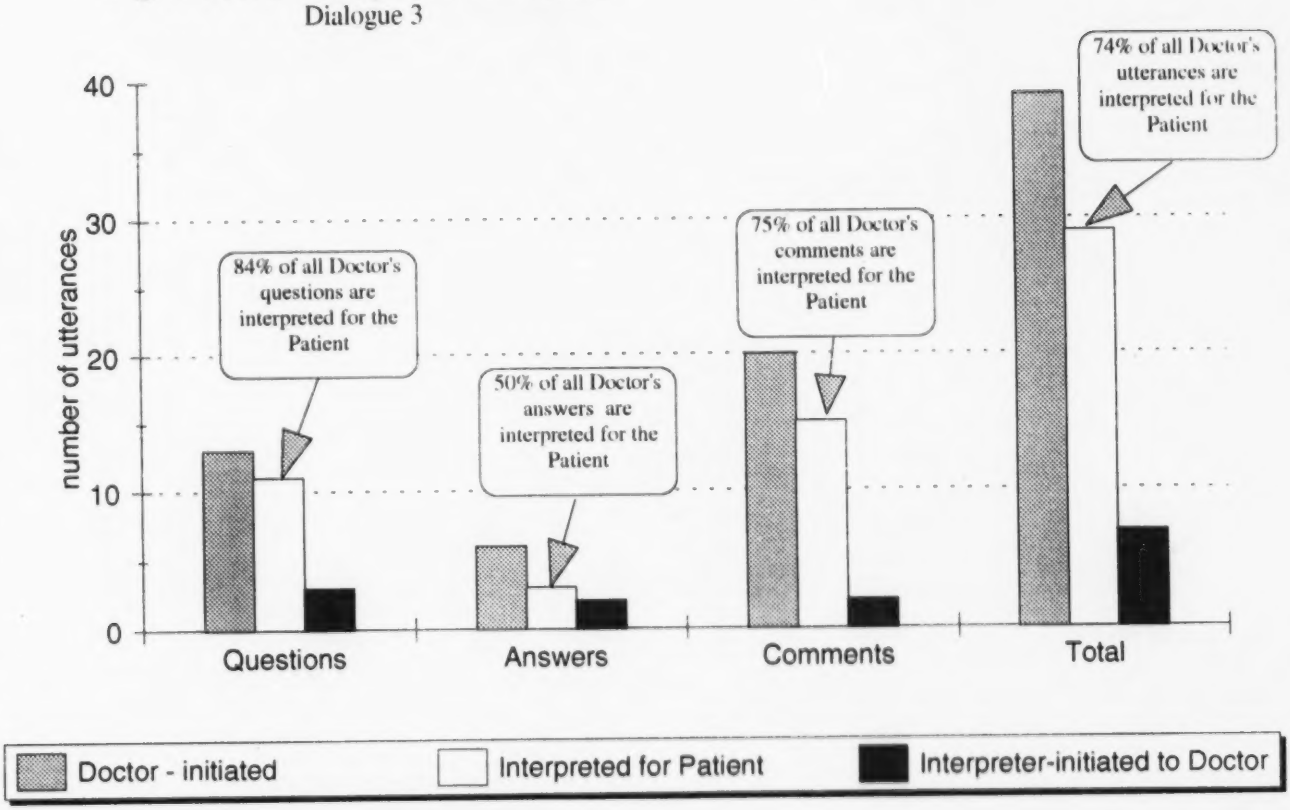


Fig 7: Patient/Interpreter Interaction

Dialogue 3

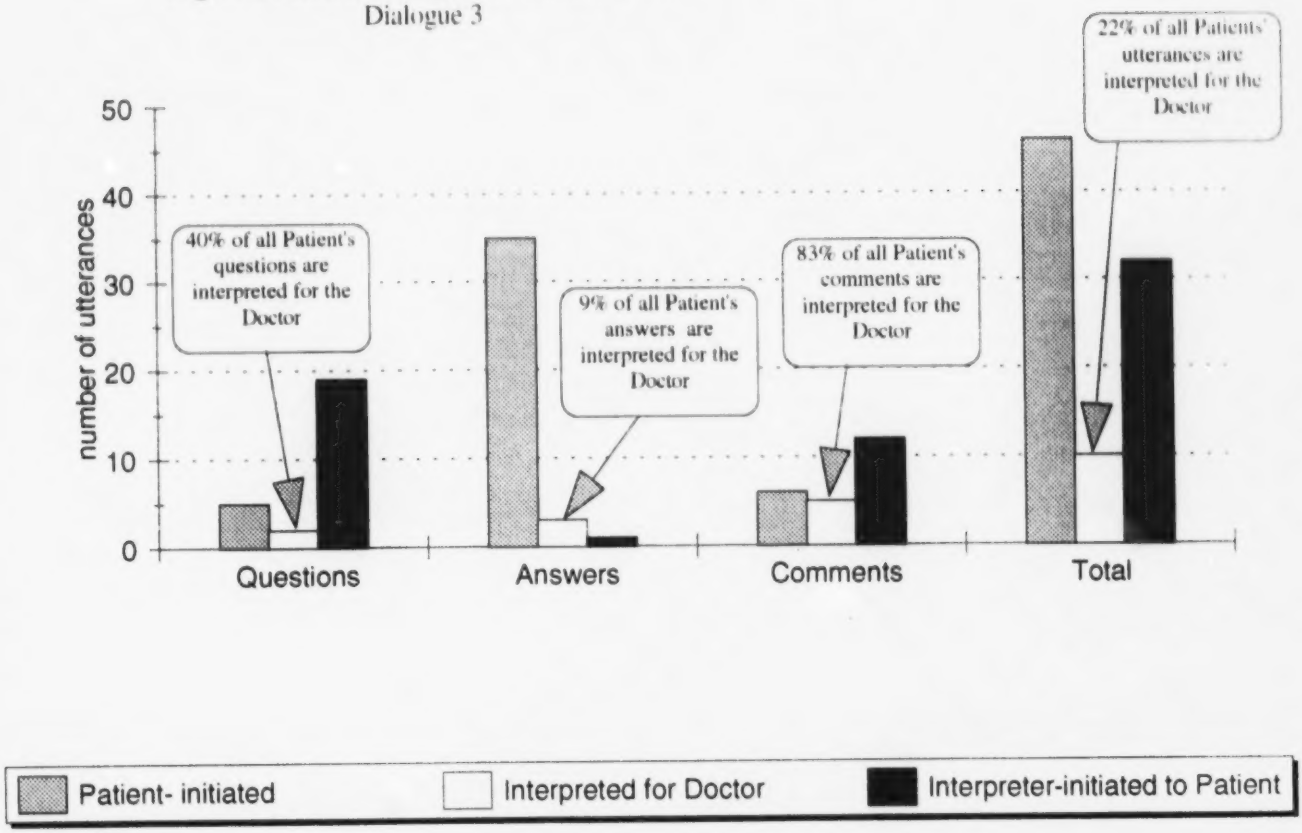


Fig 8: Doctors/Interpreter Interaction

Dialogue 4

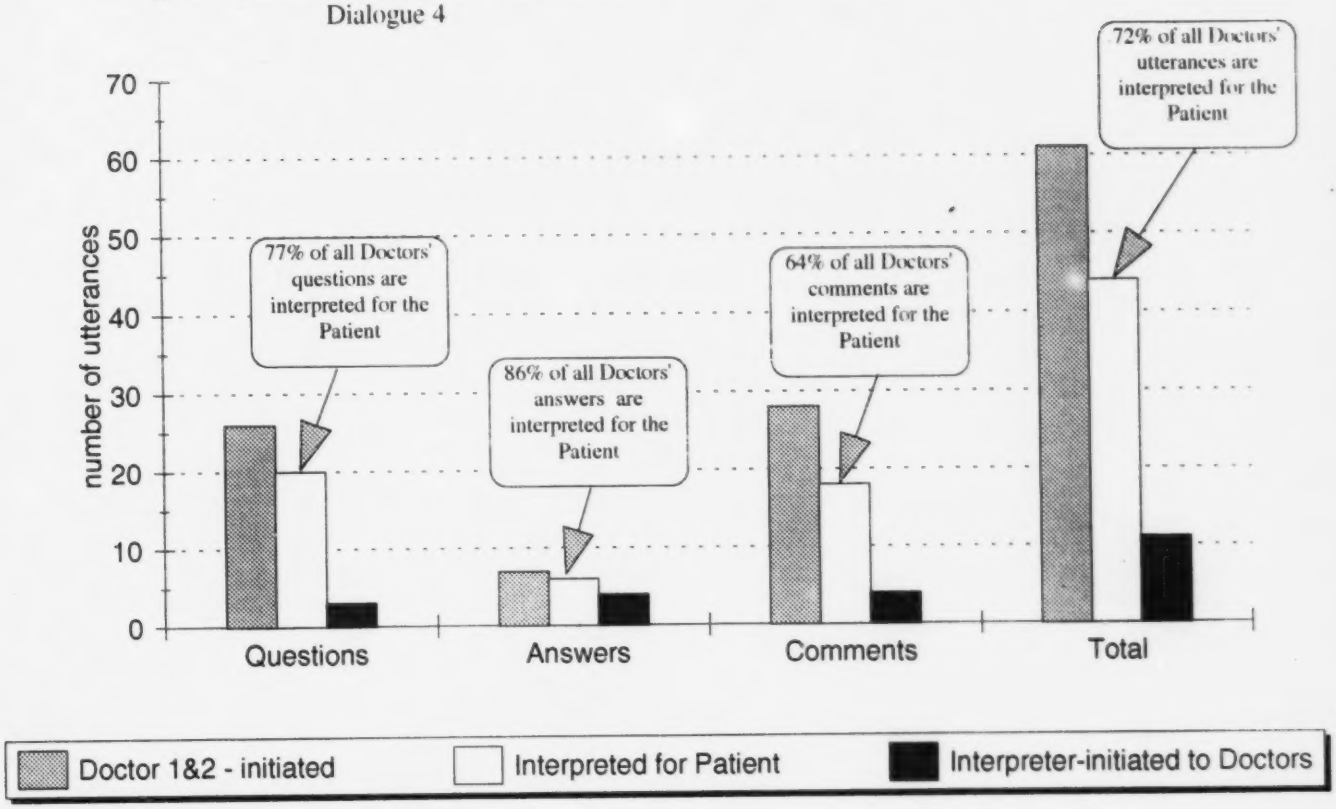
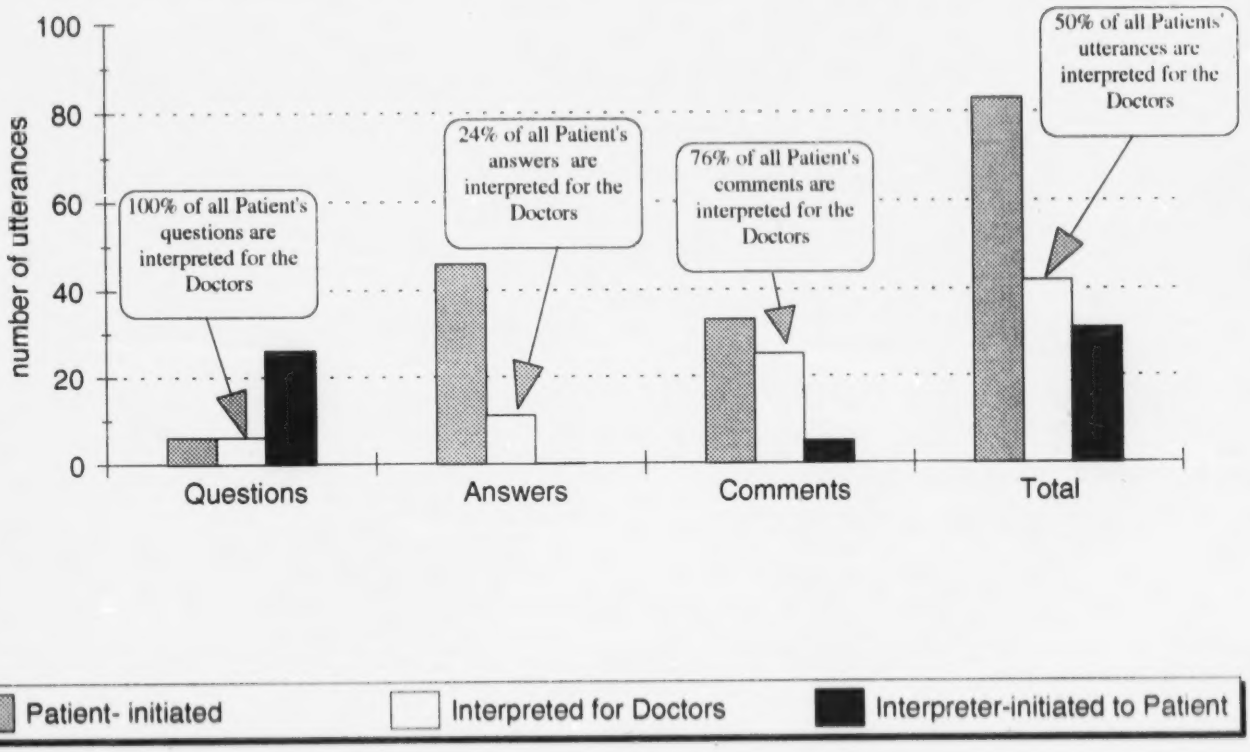


Fig 9: Patient/Interpreter Interaction

Dialogue 4



V Qualitative Analysis

A. Introduction: Interpreter's Errors

One way to evaluate the interpreter's performance is to assess the number and the gravity of errors in his/her translation of source language messages into the target language. Such analysis is, however, relevant only to the situations when the interpreter actually attempts to interpret the message. Within the model of interaction proposed in the paper, this means that only type 1 messages can be evaluated for errors since only those are translations per se. In type 2 interaction, on the other hand, the interpreter doesn't attempt to translate source language messages but, instead, participates in the conversation as an independent speaker. I will not discuss the translation errors committed by the interpreters in this paper since very few significant mistranslations are present in the data. The absence of errors may be explained by the two interpreters' high linguistic proficiency in both languages and their familiarity with medical terminology. The interpreter's influence on the doctor-patient communication is found to be much more pronounced in type 2 interactions. Instead of analyzing the interpreters' errors, I will concentrate on the discourse characteristics of the interpreter-mediated communication.

B. Turn Allocation

Researchers have noted the asymmetry that occurs in doctor-patient interactions: the doctor controls the communication, while the patient usually just follows the doctor's lead (e.g. ten Have 1991). The presence of an interpreter may influence the dynamics of the doctor-patient relationship. In fact, the interpreter may assume the doctor's power to control the discourse. The two types of interaction differ in terms of how much control over the interaction the interpreter exercises. In type 1 interaction, all interpreter's turns are pre-allocated, and, consequently, s/he has no way of affecting the organization of doctor-patient communication. Type 2 interaction, on the other hand, allows the interpreter to manipulate the discourse by controlling the distribution and the content of turns.

	Number of Interpreter-initiated Questions	
	addressed to the Doctor(s)	addressed to the Patient(s)
Dialogue 1	2	3
Dialogue 2	4	0
Dialogue 3	3	19
Dialogue 4	3	26

TABLE 7: Number of Interpreter-Initiated Questions Addressed to the Doctor and the Patient

Table 7 shows that in dialogues 3 and 4, where the interpreter uses type 2 interaction most of the time, interpreter-initiated questions are unevenly distributed between those addressed to the doctor and those addressed to the patient. The number of questions directed to the patient by the interpreter is a great deal higher than the number of questions directed to the doctor (3 versus 19

in dialogue 3; 2 versus 26 in dialogue 4). In this way, the interpreter uses his privileged position in the interaction to establish an asymmetrical relationship between him-/herself and the patient. It has often been noted (e.g. Atkinson 1992, Drew 1992, Ng 1993, ten Have 1991, West 1993) that questioning is a power strategy used to control the structure and the content of the discourse. In the medical discourse, "physicians have a privileged access to the first [(question)] position in [questioning] sequences, which gives them control of what can coherently be said in the second position as an answer, and provides them with a possibility to come back after a minimally complete answer with a third position [assessment] item, or a next question" (ten Have 1991:146).

In interpreter-assisted medical discourse, the interpreter may take over the physician's interrogating strategy. While the doctor may still have access to the first position in the questioning sequence, the interpreter monopolizes the subsequent turns. The following extract demonstrates a questioning sequence in which the interpreter uses his turns to evaluate the patient's answers and to put forward his own questions:

Extract 14 (dialogue 3)

21		D:	Ah are you ah having a problem with chest pain (?)
22	→	I:	*Do you have a chest pain (?)*
23		P:	*(4) Well how should I put it (so so) it happens sometimes (.)*
24	→	I:	*Once a week (?) once every two weeks (?)=*
25		P:	*=Sometimes it happens depending on the circumstances*
26	→	I:	*Well at: this moment of life your circumstances cause you pain once a week or or more often (?)*
27		P:	*Sometimes more often*
28		I:	*Sometimes more often*
29		I:	Once or twice a week maybe and:
30	→	I:	*this- this has to do with stress right (?)*
31		P:	*Yes*
32	→	I:	*Not with the physical work (?)*
33		P:	*Well I don't do any physical work I even tried to exercise (.)*

34	→	I:	*And the heart doesn't begin to hurt when you exercise (?)*]
35		P:	*[(...)] normal breathing restores and something*
36		I:	*Um-um*
37		P:	*I have=*
38	→	I:	*=But you don't have the heart pain when you exercise right (?) or when you walk (?)*
39		P:	*Sometimes yes*
40		I:	*Sometimes there is pain*
41		P:	*Yes*
42		I:	Ah: sometimes the chest pain is stress related sometimes it is exertion related

In line 22, the interpreter starts a questioning sequence which is initiated by the doctor in line 21. The question is a *yes/no* question, and the patient's response in 23 qualifies as an appropriate answer. The interpreter accepts it and puts forward a new question (line 24). In this case, the patient's answer is not accepted and the interpreter qualifies the question in line 26 (rephrasing it as an *either/or* question). The patient's answer (line 27) is evaluated as acceptable[6] in line 28 and is translated for the doctor (line 29). The interpreter, however, continues the questioning sequence (line 30) and asks three more questions (lines 32, 34, and 38). Thus, one doctor's *yes/no* question prompted the interpreter to initiate a sequence of six additional questions. The patient's answers to these questions are related to the doctor in incomplete summary interpretations (lines 28 and 42).

In addition to creating questioning sequences launched by the doctor's question in the first position, the interpreter may also initiate his own questioning sequences by turning a comment made by the doctor into a question. The following extract demonstrates such a situation:

Extract 15 (dialogue 4)

171	D:	Good ah: : I want you to ah continue taking ah (#) ah I want you to take the Icydil two pills a day

[6] This interpreter often repeats patient's answers that are to be translated for the doctor. Repetition thus functions as an evaluative technique.

172 → I: *And you have to continue taking Icydil two pills (#) how many times a day (?)*
173 P: *Twice*
174 → I: *Absolutely right (.) //two=*
175 D: [O.K.]
176 I: *=in the morning and two at night*

In line 172, the interpreter makes a question out of the doctor's statement (line 171), thus securing his turn in the third assessment position (line 174). In this extract, the interpreter's question casts the patient in a role of a pupil and the interpreter as an examiner.

Interpreter can also influence the distribution of turns between the participants by answering their questions rather than translating the questions for the other party. In the following extract, the interpreter answers the question posed by the patient:

Extract 16 (dialogue 3)

104 D: (It's) ((the blood pressure)) about a hundred sixty four over a hundred
105 I: *Your blood pressure now is a hundred sixty four over a hundred*
106 P: *(1.5) What is the norm, you know (?)*
107 → I: *Well if you have a hypertension (,) then we believe that ah it should be in the area of a hundred forty over eighty (,) over eighty five (.) These are the upper numbers and no higher than a hundred forty and: no higher than eighty five (.)*
108 I: (1.5) Is that som- some something he needs to look for is ah: a hundred forty over eighty five or what som- //some something]
109 D: [Yeah roughly] that's what we'd like

In line 107, the interpreter answers the patient's question. In line 108, the interpreter re-addresses the question to the doctor in order to confirm the information he's provided for the patient. The doctor's answer (line 109), however, is left uninterpreted.

In sum, in a type 2 interaction, the interpreter has almost unlimited access to the floor, which s/he can use to establish an asymmetrical relationship between him/herself and the patient.

C. Information Exchange

In type 1, all interpreter's turns are scripted: s/he attempts to translate everything said by the doctor or the patient in the previous turn. Type 2 interaction, on the other hand, allows the interpreter to control the exchange of information: s/he may choose to withhold information presented by the parties or to add his/her own comments, explanations, etc.

	Number of Translated Utterances (% total)	
	from the Doctor to the Patient	from the Patient to the Doctor
Dialogue 1	71%	83%
Dialogue 2	79%	64%
Dialogue 3	74%	22%
Dialogue 4	72%	50%

TABLE 8: Percentage of Utterances Translated by the Interpreter for Each Party

The analysis of the data collected for the study shows that when the interpreter conducts a type 2 conversation, more of the doctor's utterances are translated for the patient than visa versa (see Table 8). In dialogue 3, for example, 74% of the doctor's utterances are interpreted, but only 22% of the patient's. While content analysis is needed to determine how much information is passed between the parties in summary interpretations, the data in Table 8 suggests that in a type 2 interaction, more information is passed from the doctor to the patient than from the patient to the doctor.

When translating the patient's words, the interpreter is often found to offer summary rather than complete interpretations. In dialogue 3, for example, 31% of all interpreter's turns in English are summary interpretations of the patient's words (see Table 5). In summary interpretations, the interpreter may choose to ignore "those aspects of patients' utterances that report on subjective experience, personal circumstances and social conditions" (ten Have 1991: 141). This "context-stripping" strategy often used by physicians is adapted, in my data set, by one of the interpreters (*interpreter B*, dialogue 3 and 4) who filters the information deemed irrelevant out of his interpretations.

Interpreter B uses a context-stripping strategy in extract 14 (see the previous section). Lines 29 and 42 are summary interpretations of the patient's utterances in lines 23, 25, 27 and 31, 33, 35, 37, 39 respectively. Note that the summary interpretations include only medical information about the patient's condition but none of the social or personal context. For example, the patient's statement that his heart condition depends on the circumstances of his life (line 25) and that he doesn't get to do any physical work (line 33) are not conveyed to the doctor.

The interpreter not only filters out the information s/he deems unrelated to the patient's physical condition, but may also omit information that clarifies the patient's medical problems. The following extract demonstrates such a situation:

Extract 17 (dialogue 3)

43	D:	Has it ((chest pain)) ever awakened you from sleep at night (?)
44	I:	*Do you ever wake up ah- at night (?)=*
45	P:	*=Yes yes=*
46	I:	*=Because of the heart pain (?)*
47	P:	*Yes it happens*
48	I:	Yes

49		P:	*Ah (6.5)*
50		D:	What what kind of pain is it (.) is it a sharp pain or dull pain (?)
51		I:	*Could you describe your pain (?) is it a dull pain, a sharp one (#) or the pressure (?)*
52		P:	*Well what kind of pain it sometimes happens that well if I well I tried to exercise (,) it seems to me that well my heart stops (.) I have to move back and forth to=*
53		I:	*=That is it is not a pain (?) rather just the feeling that your //heart stops]*
54		P:	*[Pain also (,)] there is pain //<u>of course too</u>]*
55		I:	*[And what kind of] pain (,) dull (,) sharp or pressure (.)*
56		P:	*Well there is pain in the heart (#) how can I explain it (.) //I don't know]*
57		I:	*[There are different] kinds of heart pain it may be a sharp pain (,) or it may be a dull pain (,)or the heart may feel as if squeezed what kind of heart pain do you have (?)*
58		P:	*Well (#) not like constantly but periodically sometimes there is such a pain that I mean I can't bear it (,) seems like it's gonna stop and that I kind of have to move I can't //sit still]*
59		I:	*[But] can't you say if it is sharp or dull (.) sharp means a lot of pain and acute as if with a knife (,) and dull means it's more like pressure*
60		P:	*No not sharp*
61		I:	*Not sharp*
62		P:	*No not sharp*
63	→	I:	So it's more of a dull pain and he has a hard time ah describing it (,) ah at the same time ah he it feels like the heart is going to stop (.)

In line 63, the interpreter gives a summary interpretation of his discussion with the patient (lines 51-62). The summary interpretation omits any reference the patient makes to the facts that exercise may cause heart problems (line 52) and that his pain can be so bad that he cannot sit still (line 58).

In my data, interpreters are also found to expand on the information presented by one of the parties. Most of the time, the expanded translations occur when the interpreter translates the doctor's words for the patient elaborating on the source message. The following is an example of the interpreter's elaboration of the doctor's words:

<u>Extract 18</u> (dialogue 3)

189	D:	I know ((quitting smoking)) it's not easy but it's the best ah: present or gift you can give yourself (.)

190		I:	*This is not easy but this is the best gift you can give yourself=*
191		I:	=Ah do we still have this Smoking Cessation Clinic (?)
192		D:	Right (,) ah the problem with //we have this]
193		I:	[They don't pay] for it (.)
194		D:	Well that's a part of it but because of his heart disease medication probably will be ah he couldn't get it because of his heart=
195		I:	OK
196		D:	=I think (.) At least until we get his heart cleared (.)
197		I:	OK OK
198	→	I:	*After you have done the test ah: the heart test (,) when you come back here we'll talk about the possibility that maybe we'll refer you to a special clinic (,) where they help people quit smoking (.) (#) They have sort of nicotine patches there which they put on your body and you then quit smoking we have many people who quit (,) but you have a problem because of the heart and if you have heart problems they can't admit you to the clinic (,) you can't wear those patches (.) If however the results of your test are good we will be able to talk about it (,) OK (?)*
199		P:	OK
200	→	I:	*OK (.) So take your medications and don't be afraid to get dependent on them ( )*

In lines 198 and 200, the interpreter elaborates on the information he receives from his conversation with the doctor in lines 191-198. In the elaboration (line 198), he not only provides an explanation of the medical treatment, but also misrepresents the doctor's words when he says that the patient's admittance into the Smoking Cessation Clinic depends on the results of the stress test (line 198). In line 200, the interpreter offers medical advice that hasn't been mentioned by the doctor at all.

In sum, the interpreter may control the exchange of information between the doctor and the patient by providing summary rather than complete interpretations or elaborating on the words of one of the parties.

D. Structure of Discourse

The interpreter can control a conversation by determining the type of interaction that takes place. At every turn, the interpreter can choose to either change the type of interaction suggested by the speaker in the previous turn (from type 1 to type 2 and *vice versa*) or to continue in the same interactional mode.

The interpreter can juxtapose discourse conventions of the two interactional modes in order to manipulate social distancing in a medical encounter. In type 1 interaction, the interpreter is expected to preserve personal pronouns used by the speaker. Thus, the interpreter working in type 1 would use the first person pronoun to refer to the speaker whose words are interpreted. However, if the interpreter works in type 2 mode, a sudden shift to type 1 may cause the addressee to understand the first person pronoun in the speech of the interpreter as a reference to the interpreter and not to the previous speaker. The interpreter, therefore, may choose to move to type 1 interaction in order to be identified with one of the parties. In the following extract, the interpreter redefines the conversation as type 1 to translate the doctor's words:

Extract 19 (dialogue 4)

147 D: Ah: I think it would work ah better for you if you used it at least two or three times a day (.)

148 → I: *I believe that it would be more helpful for you if you used the cream two or three times a day (.)*

In line 148, the interpreter preserves the original first person pronoun "I" thus defining the exchange as a type 1 interaction. Since up to that point it was a type 2 conversation, the patient may misunderstand line 148, thinking that the author of the medical advice is the interpreter rather than the doctor. Thus, the interpreter's status rises in the eyes of the patient.

Interpreter-initiated shift of conversation from type 2 to type 1 does not always result in raising the interpreter's status. In extract 20, the interpreter defines the conversation as a type 1 exchange while translating the patient's complaint:

Extract 20 (dialogue 4)

123		P:	*Even now my leg is swollen and what is going to happen in the summer (#) it will be horrible*
124	→	I:	My leg is swollen right now (,) what is it going to be like in the summer (.) It is going to be twice (#) ((softly:)) its normal size

In this case, however, the apparent identification with the patient can not be misunderstood, since the doctor knows that only the patient can complain about his/her medical problems during the course of a medical interview.

The interpreter may choose to shift a type 1 interaction to a type 2 interaction. Such a transfer may result in raising the interpreter's status if it is done during the questioning stage of the interview. We have seen this happening in Extract 14, where the doctor's question (line 21) defines the exchange as type 1 and the interpreter's translation of the question (line 22) is neutral (i.e. it can be both type 1 and type 2). However, in line 24, instead of translating the patient's response for the doctor as type 1 requires, the interpreter continues his own questioning and, thus, redefines the exchange as type 2.

Another example of such transition is extract 21:

Extract 21 (dialogue 4)

187		D:	Now if if you want you can also take ah Tylenol along with this (.)
188		I:	*If you want to you can take Tylenol in addition to this*
189		P:	*Um-um*
190	→	I:	*But don't take it //more than once]*
191		P:	*[Have him] give me a prescription for cream for*

192 I: *The one you have now or what (?)*
193 P: *No the one the one I put on //I took it before]*
194 I: [Oh] (.) She wants a refill for this cream
195 D: Do you need any other refills today (?)

In this extract, the doctor attempts to construct a type 1 discourse (note "you" to address the patient in lines 187 and 195). Line 188 is neutral. However, in line 190, the interpreter self-selects himself to offer a piece of medical advice, thus converting the conversation into a type 2 interaction as well as redefining lines 188-190 as a type 2 exchange. Note that the patient accepts this definition of the discourse ("him" in line 191), but the doctor repeats his attempt to shift to type 1 (line 195).

Interpreter-initiated transitions from type 1 to type 2 interaction do not always result in the interpreter's status building. The interpreter may have to switch to type 2 to request clarifications from one of the parties. The following extract demonstrates such a situation.

Extract 22 (dialogue 1)

18 D2: Can you- can you tell me what happened this morning (?)
19 I: *How- what happened this morning (?)*
20 P: *Everything was as usual (.) I have hypertension (.)=*
21 I: *Um-um*
22 P: *=and apparently my blood pressure //went up]=*
23 I: *[Um-um]*
24 P: *=and I took my //Cofelin (,)]=*
25 I: *[Um-um]*
26 P: *=this is a medication (,) and we drove here (.)=*
27 I: *Um-um*
28 P: *=then my son decided to move the car to a //new]=*
29 I: *[Um-um]*
30 P: *=place to a different //parking]=*
31 I: *[Um-um]*
32 P: *=lot and the strong wind began to blow=*
33 I: *Um-um*
34 P: *=and all of a sudden I began to feel kind of very //uncomfortable (.)]*
35 I: [O.K.] Everything was just normal everything was O.K. (,) and: uh: we were gonna to the hospital and it was- I am hyper- I have hypertension so I

probably did have a high blood pressure in the morning (.) I've taken my pill and //the name of the pill is

36 → *What is the name]*
37 P: *[And two years ago I had a heart attack]*
38 → I: *=what is the name of your pill (?)*
39 P: *Nitroglycerin*
40 I: Oh I've taken nitroglycerin and but then //it]

In this extract, up to line 36, the conversation is in type 1. In line 36, the interpreter initiates a transfer to type 2 to request a clarification from the patient. As soon as clarification is received, the interpreter shifts the conversation back to type 1 (line 40).

Repairs resulting in transfer from type 1 to type 2 interaction may be initiated by other parties. In the following extract, the doctor initiates the shift to type 2 interaction to clarify the interpreter's words:

Extract 23 (dialogue 2)

114 D: What- what was she allergic to again (?)
115 I: *What were you allergic to (?)*
116 P1: *To all anesthesia to all kinds of Novocain medications well in general to anesthesia* (.)
117 I: O.K. anesthesia (,) all kind of anesthesia and Novocain related
118 → D: Novocain (?)
119 I: Novocain
120 D: ((slowly:)) Novocain (?)
121 I: Yeah
122 P2: *They don't know it here=*
123 I: *=They do (!)=*
124 P1: *=They do (!) they //also have Novocain]*
125 I: *[They do] (#) they do*
126 P1: *They also have //Novocain]*
127 I: [Should I] write it down for you (?)
128 D: Yeah
129 I: O.K. ((writing)) (2)
130 P2: *But here they don't use it somehow because many times I've-*
131 D: Oh: yes (!)
132 I: O.K. do I pronounce it in the wrong way (?)
133 D: Yeah
134 I: How do you say it (?)
135 D: Novocain

136 I: Novocain
137 D: How did you say it (?)
138 I: Novocain
139 D: Ah=
140 I: =The stress was on the wrong syllable O.K.
141 P2: *Well here it somehow isn't=*
142 I: *=No no / they]*
143 D: [All right]
144 I: *=do have it I just put the stress on a wrong syllable Novocain* Novocain

In this extract, the doctor requests a clarification in line 118 thus launching a type 2 interaction. The misunderstanding is cleared by line 131, but a type 2 interaction continues. In spite of lines 123 and 125 where the interpreter comes across as an authoritative figure, any raise in status she might have gained was lost by line 144 when the interpreter explained that the misunderstanding was her fault.

In sum, changes in conversational organization can be attempted by all parties. Interpreter-initiated changes may or may not result in raising his/her status depending on the particular conversational context of the shift. The shift functions as a power strategy if it results in the interpreter's identification with the doctor and/or allows him/her to adopt the doctor's discursive techniques.

CONCLUSIONS

Analysis of interpreter-mediated doctor/patient encounters shows that interpreters can control the conversational organization of the medical interview, the distribution of turns among the participants, and the exchange of information between the doctor and the patient.

This analysis shows that type 1 interaction (when the doctor and the patient communicate directly through an interpreter) should be a preferred conversational mode because it approximates more closely normal, monolingual doctor-patient interactions and facilitates the exchange of information between the two principal parties. By contrast, type 2 interaction may result in a situation where the interpreter controls what's being said and who gets to talk, and minimizes communication between the doctor and the patient. Clearly, it is possible for this to result in misdiagnosis and mistreatment and, thus, diminish the quality of care received by patients of limited English proficiency.

The paper presents only an explorative study of interpreter-mediated doctor/patient communication. The following are some directions for further research:

- develop a tool that would allow to analyze the content of the interpreter's utterances and to compare the information expressed in them to the information presented by the principal parties (the patient and the medical provider);
- analyze how each type of interaction contributes to creating or diminishes the chance of miscommunications between the parties;

- analyze the influence of such factors as topic, situational task, etc. on the choice of the interactional mode;
- immediately after an interpreter-mediated conversation is recorded interview the participants to determine their reactions to the way the session has been conducted and the quality of their interaction with the other parties.

The study presented in this paper has demonstrated that in order to solve the problem of language barriers in health care, educational programs focused on developing an understanding of the interpreter's role and conversation management skills are needed for *all* participants in interlingual medical encounters: not only interpreters, but medical providers and patients as well.

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APPENDIX 1: TRANSCRIBING CONVENTIONS[1]

//	the point at which one speaker is overlapped or interrupted by another
//]	overlapped or interrupted part of the utterance
[ ]	the portion bracketed overlapped or interrupted a previous speaker's utterance
:	the immediate prior syllable is prolonged
=	no time lapses between the latched utterances
-	a hitch or a stutter on the part of the speaker
(.) (,) (?) (!)	intonation marks
(word)	the transcriber is not sure what was heard
( )	something was said but not caught by the transcriber
((softly))	descriptions
(#)	short pause under one second
(number)	length of the pause in seconds
(/word/)	phonetic transcription; follows the orthographic representation
<u>underline</u>	stressed or emphasized segment
italics	translation from Russian
CAPITAL	doctor's words pronounced in Russian
((=word))	translation of the doctor's words in Russian

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[1] Adapted from Jefferson's conventions (cit. in Thorne 1975:128-129).